FCC Docket Number
WC Docket No. 02-60

FCC Pilot Program Quarterly Report
July - September 2011
Erlanger Health System

1. Project Contract and Coordination Information

a.b. Identify the project leader(s) and respective business affiliation

Douglas Fisher (Project Coordinator)
VP Government & Community Affairs
Erlanger Health System
975 East Third Street
Chattanooga TN 37403
423-778-9642
douglas.fisher@erlanger.org

Hale Booth (Associate Project Coordinator)
Executive Vice President
BrightBridge Inc.
PO Box 871
Chattanooga, TN 37401
423-667-2077
hbooth@BrightBridgeInc.org
Fax 423-424-4262

c. Responsible organization
Erlanger Health System
975 East Third Street
Chattanooga TN 37403

d. Coordination throughout the state or region.
Erlanger Health System continues periodic discussions with other health care providers across the region regarding the network system as Erlanger seeks to meet specific needs of the individual health care providers.

2. Identify all health care facilities included in the network.

For the initial FCC funded rural fiber healthcare network the facilities listed below are primarily the same as those proposed in the application. All of these facilities have submitted a Letter of Agency on behalf of the Erlanger Health System project and are included in the 465 and 466-A postings.

Copper Basin Medical Center — Public, non-profit eligible
144 Medical Center Drive
Copperhill TN 37317
RUCA Code 10
Census tract 9504
Contact Alexander Altman, CEO/CFO 423-496-8126

Erlanger Bledsoe — Public non-profit eligible
128 Wheeler Town Road
Pikeville, TN 37367
RUCA Code 10
Census Tract 9531
Contact Douglas Fisher, 423-778-9642

Erlanger Baroness (including Children's) — Public non-profit eligible
975 East Third Street
Chattanooga, TN 37403
RUCA Code 1
Census tract 4
Contact Douglas Fisher 423-778-9642

Erlanger North — Public non-profit eligible
632 Morrison Springs Road
Red Bank TN 36415
RUCA Code 1
Census Tract 109
Contact Douglas Fisher 423-778-9642

Hutcheson Medical Center — Public non-profit eligible
100 Gross Crescent Circle
Fort Oglethorpe, GA 30742
RUCA Code 1
Census tract 307
Contact : Debbie Reeves Intérim CEO 706-858-2000
(Erlanger Health System has taken over management and operation of north Georgia based Hutchison Medical Center effective in April 2011,

This was necessary because the previously free standing hospital was facing imminent bankruptcy and closure).

North Valley Medical Center 723 Rankin Avenue (US 127) Dunlap TN RUCA Code 10 Census Tract 601 Contact: Claude Lewis 423-949-3479	Transitioning to non-profit (Dedicated emergency department)

(North Valley MC management is in flux, the private for profit operator has withdrawn emergency services from the Dunlap location and the facility owner the Sequatchie County Government has recently entered into a letter of intent with Erlanger to come in and operate the service, EHS has requested a reclassification of the facility by Medicaid to make patient care reimbursement economically viable. The final decision on the service provider has not been finalized pending a response on the reimbursement issue).

Rhea Medical Center 9400 Rhea County Highway Dayton TN 37321 RUCA Code 8 Census tract 9752 Contact; Ken Crooms CEO, 423-775-1121	Public non-profit eligible

Erlanger East 1755 Gunbarrell Rd Chattanooga, TN 37421 RUCA Code 1 Census Tract 114.41 Contact; Douglas Fisher 423-778-9642	Public non-profit eligible

Murphy Medical Center 4130 U.S. Highway 64, East Murphy North Carolina 28906 RUCA Code 9 Census tract 9906 Contact: Mike Stevenson CEO, 828-835-7502	Public non-profit eligible

3. Network Narrative:

A contract has been executed between Erlanger Health System and EPB for network design. A Funding Commitment Letter has been issued for the network design work and EPB is beginning to meet with planned rural healthcare network users to develop information needed for the network design.

4. List of connected health care providers.
Not applicable at this time.

5. **Identify the following non-recurring and recurring costs, where applicable show both as budgeted and actual incurred for the applicable quarter and funding year to date.**

	Budgeted	incurred
a. Network design	45,000	0
b. Network equipment	360,000	0
c. Infrastructure deployment		
i. Engineering	0	
ii Construction	956,600	
d. Internet2, NLR	0	0
e. Leased facilities	1,125,000	
f. Network management, maintenance, O&M	0	0
g. other	0	
Total	2,586,600	0

6. Describe how costs have been apportioned and the sources of the funds to pay them.

a. Explain how costs are identified, allocated among and apportioned to both eligible and ineligible network participants.

The network will initially only serve eligible participants which are non-profit health care providers and at least one free standing emergency care department of a for profit hospital, which is eligible under the criteria. Generalized expansion plans have been developed and funding applications will continue to be submitted to serve a planned future broader range of rural hospitals and primary health care providers, some of which would be defined as ineligible participants for the FCC funded network. If and when non-FCC funding requests for this health care network expansion are successfully funded and these additional rural health care providers become a part of the system, this issue of apportioning costs will be addressed with the funding agencies. It is anticipated that when the time comes to add ineligible network participants, the rural healthcare network will assess a reasonable one time

up front fee to these ineligible participants based upon anticipated bandwidth needs and let the ineligible participants manage their own capital costs for "last mile" access to the network.

Rural Healthcare Network project partners have also successfully applied for additional funding opportunities available through the ARRA "stimulus bill" for use with the telemedicine network. In October 2009, major "stimulus" funding was announced by DOE for one of the public existing service providers in the service area. This development has positively benefited the rural healthcare network by paying for a portion of the needed fiber construction, on which the healthcare network will ride.

b. Describe the source of funds from:
   i. Eligible pilot program network participants.

      Network participant hospitals are not being asked to contribute to the 15 percent project match as most of these rural partner hospitals are struggling to simply stay in business and keep their facilities open through the current severe economic downturn. (Out of necessity project staff have been investing considerable time during the course of this project in seeking federal funds to keep both the Copper Basin Medical Center in Polk County, the North Valley Medical Center in Sequatchie County, and Hutcheson Medical Center in north Georgia open for business).

      A number of difficulties were encountered in developing an acceptable match for the FCC funds. As a result of these difficulties in providing an acceptable match, the Board of Directors of BrightBridge Inc. (a regional non-profit economic development corporation assisting EHS with this project) approved the use of Direct Congressional Appropriation funds previously appropriated to BrightBridge Inc. for use in construction activity to complete matching funding of the FCC project. BrightBridge staff traveled to Washington DC to meet with HUD officials who have financial oversight of these matching funds to review the proposed use of these Direct Appropriation funds to match the FCC grant. At this meeting HUD officials agreed this rural telemedicine network is an acceptable project which meets the guidelines of the grant and requested that staff submit a revised environmental assessment and other forms.

      Erlanger Health System has also received $352,000 in additional project grant funds from USDA Rural Development for non FCC-eligible network equipment that is being placed in rural hospitals.

As previously mentioned, one of Erlanger Health System's existing service providers, the non-profit Electric Power Board of Chattanooga (EPB) received notice from DOE in October 2009 that EPB's grant application for SmartGrid funding (which was prepared by BrightBridge Inc. and coordinated with the rural healthcare fiber network plans) was selected for $111,567,606 in DOE funding to match a local EPB commitment of $115,139,956. A significant portion of this new DOE funding has been used to extend high speed fiber "wall to wall" across the multi-county service area of the Electric Power Board, resulting in the nation's fastest internet service. This additional fiber construction has now been completed and is a major project development for the Rural Health Care Fiber Network. Now there should not be any FCC funded fiber required to be constructed in the large EPB service area as the healthcare network data can lease capability and "ride" the EPB fiber. This will hopefully allow the FCC funded fiber to reach further into rural areas and help position the rural healthcare fiber network for additional future expansion.

Project planners have held meetings with other non-profit regional electric distributors and have determined that there is significant fiber available in these adjoining utilities which while not commercially available, will be made available to the rural health care network by the utilities in a pre-lease arrangement. This again will increase the effective reach of the health care network in a cost effective manner by reducing the need for new construction to just a few smaller corridors where there are gaps in fiber.

These positive developments are reducing participant cost to an operating and maintenance fee which is being defined as part of the network design process. The target spot for this operating and maintenance fee is slightly less than the price of a T-1 for up to 10 mg service. If this can be achieved it will allow approximately 6 times the bandwidth for approximately the cost of a traditional T-1 connection.

Erlanger and the various project partners are also looking long term toward a non-profit partnership for ownership, operation and maintenance of the network which results in some of the partners bringing matching cash equity to the project as well as other needed investments. The partnership under development would be Erlanger Health System, BrightBridge Inc. a SBA, HUD, EPA (etc). certified non-profit economic development corporation and some area public power distributors which have the staff, rights-of-way, fiber and physical capability needed to maintain the fiber network. Preleasing service and the availability of fiber connectivity, will not initially require such a partnership. However, the long term expansion and growth of the network can be better served by this type of non-profit

partnership. Now that network design services have been contracted, organizational structural arrangements for this partnership are developing more quickly.

ii. Ineligible network participants.

Not applicable (at this time).

c. Show contributions from all other sources

i. Identify source of financial support and anticipated revenues paying for costs not covered by the fund and by pilot program participants.

The FCC grant award for the Rural Healthcare Fiber Network has enabled the project to leverage a sizable investment of federal and local funds to assist with costs not covered by the FCC grant. Major costs and funding have been as follows: a) planning, project administration, and network management equipment; b) operating equipment; c) CBMC radiology equipment; and d) DOE fiber funding.

a) Erlanger Health System continues to incur costs for planning and project administration assistance along with costs for network management equipment. These costs are not covered by the grant and are currently being paid by Erlanger Health System. Grant eligible costs are not being incurred at this time as EHS has only recently received the first Funding Commitment Letter (FCL). However planning and project administration for pre-bid documentation such as Sustainability Plan, LOA's, FCC form 465 submittals, Request for Proposals, 466-A Forms and supplemental documentations have been completed. In addition Erlanger Health System has invested $228,065 in purchase of a codian bridge to manage the network.

b) The need for operating equipment to interface with the FCC funded fiber network is an essential component not funded by the FCC grant. To meet this need, Erlanger Health System successfully applied for telemedicine equipment funding from the USDA Rural Development Distance Learning Telemedicine program. This funding request was for non-FCC eligible network equipment to be located in rural Copper Basin Medical Center in Copperhill, Rhea County Medical Center in Dayton, Erlanger Bledsoe in Pikeville, North Valley Medical Center in Dunlap and Erlanger Baroness in Chattanooga. These telemedicine stations have been bid and purchased and agreements have now been executed for the remote deployment of these telemedicine stations. They are initially operating over an existing patchwork system of lower capacity leased copper lines such as T-1's.

c) One of the key needs that initially emerged out of network planning with Copper Basin Medical Center involved tele-radiology. Copper Basin was the only hospital in the pilot project without a PACS or digital imaging system, from which important diagnostic imagery could be transmitted over the FCC funded rural healthcare network. A commitment of federal funding through the Appalachian Regional Commission was secured to assist with the purchase of a portion (fifty percent) of the PACS system, for Copper Basin Medical Center. The balance of funding for this system was included in the previously mentioned USDA Rural Development Distance Learning Telemedicine grant awarded to Erlanger by the USDA. The PACS equipment is now in use; EHS requested and disbursed the remaining USDA funds needed to complete the purchase payment for this PACS equipment.

During the reporting quarter project staff initiated a new grant application to the Appalachian Regional Commission for the Copper Basin facility to purchase a new digital CT scanner that will be integrated into the telemedicine network. A decision on the grant proposal is not expected from ARC until the late spring of 2012.

d) As mentioned previously in this report, the US Department of Energy (DOE) awarded major DOE funding to the local non-profit Electric Power Board to complete comprehensive installation of high speed fiber throughout the rural portions of their six county service area. Project administrative staff worked with the Electric Power Board of Chattanooga (EPB) to prepare, write and submit an ARRA SmartGrid Investment Grant Application to the Department of Energy. This grant application to the DOE Office of Electricity Delivery & Energy Reliability, while an electrical system application, included extensive installation of a high speed fiber communications network to all customers and areas of the multi-county EPB service area. The majority of these areas served by the grant are outside of the urban core of Chattanooga and are characterized as very rural. DOE announced $111,567,606 in grant funding for the project in October 2009 and installation has recently been completed. While not a direct part of the FCC funded project, this has significantly leveraged the FCC funding as the DOE funding has paid for construction and development of some of the necessary fiber that had been previously anticipated to be installed as part of the FCC project. This in turn will allow the FCC funded Rural Health Care Fiber Network additional flexibility for fiber leasing

or construction to potentially serve even more distant rural locations for the FCC funded healthcare network. In essence this could be a way to expand or improve planned service to additional rural public health centers in the region.

ii. Identify the respective amounts and remaining time for such assistance.

No additional time is needed to raise financial assistance. That is now done. All RFP have been posted and the first contract for network design has been negotiated and executed. Raising eligible matching funds in the current economic environment has been a time consuming task which initially delayed the project. The total FCC project budget submitted is $2,586,600. The source of funding is $2,198,610 from the FCC Pilot grant and $387,990 in local matching funds which are from an awarded Direct Congressional Appropriation grant to BrightBridge Inc.

Erlanger Health System is investing additional hundreds of thousands of dollars of local funds designated for purchase of network equipment necessary to manage and operate the fiber network. A large portion of this Erlanger investment, $228,065 has been expended on a codian bridge needed to manage the network.

d. Explain how the selected participant's minimum 15 percent contribution is helping to achieve both the selected participant's identified goals and objectives and the overarching goals of the pilot program.

Erlanger Health System has planned the deployment of the FCC Rural Fiber Network from the inside of their health system out to the rural partners. As part of this systemic process, Erlanger has identified necessary equipment capacity needs for the network that can grow with the network over time. This telemedicine investment along with the FCC Pilot grant supports Erlanger Health System's role as a regional tertiary care provider and a strong partner for the growth of healthcare services in rural communities. It also positions EHS and partners to grow the network into a component of a future national healthcare fiber network.

The 15 percent matching funds contributed by BrightBridge will be invested as a pro-rata share with the 85 percent FCC funds to help achieve the goal of building the project.

7. Identify any technical or non-technical requirements or procedures necessary for ineligible entities to connect to the participant's network.

At this time, no plans have been developed for ineligible entities to connect directly to the network, so this question is not currently applicable. Meetings with rural electric distributors across the region which anticipate supplying fiber linkages have indicated that it will be possible with very little additional expense to serve several additional eligible dedicated emergency centers of rural for profit hospitals. As the system develops, the rural healthcare fiber network certainly anticipates serving dedicated emergency centers of area private for profit hospitals which survive the economic recession/depression; however these dedicated emergency departments would be an eligible recipient under current pilot program guidance.

Erlanger Health System is not aware of any issues around ineligible entities i.e. medical practices and doctor groups interfacing through Erlanger's hub/network terminus with data carried on the pilot rural healthcare network. This is important to the long term success of the system as the local public Electric Power Board (EPB) of Chattanooga has now completed the total investment of approximately $350,000,000 to extend high speed fiber ("last mile-fiber to the home") to all of their 170,000 customers throughout their 600 square mile urban/rural service area which is where the vast majority of the regions tertiary care medical specialists live and work. The ability of these specialists to link from any urban location to the hub or terminus of the health care network at Erlanger through EPB's new fiber network is vital to the long term success of the rural healthcare project and critical to the ability of the network to respond effectively in a crisis or large scale medical emergency as envisioned by HHS or the CDC.

We are assuming that if the FCC network terminates at the participating hospitals, then the participating hospitals can send various data to various other local locations or medical service providers utilizing other secure but non-FCC funded networks such as local area networks (LAN's), secure wireless networks, private networks, etc. We have reviewed this strategy with staff of the GAO who were researching the FCC Pilot Program and they did not indicate any programmatic compliance concerns with this assumption. This is a very important assumption for the rural healthcare network that will be critical to the adoption and success of our business model.

8. Provide an update on the project management plan, detailing:

a. The project's current leadership and management structure and any changes to the management structure since the last data report.

The USAC designated points of contact remain the same with current leadership for the project provided by Douglas Fisher, Erlanger Vice

President for Government and Community Affairs (Project Coordinator), and Hale Booth, Executive Vice President, BrightBridge Inc. (Associate Project Coordinator). There are also other key managers within both Erlanger Health System and BrightBridge who are involved in the development of the pilot project.

b. In the first quarterly report, the selected applicant should provide a detailed project plan and schedule. The schedule must provide a list of key project deliverables or tasks, and their anticipated completion dates. Among the deliverables, participants must indicate the dates when each health care provider site is expected to be connected to the network and operational. Subsequent quarterly reports should identify which project deliverables, scheduled for the previous quarter, were met, and which were not met. In the event a project deliverable is not achieved, or the work and deliverables deviate from the work plan, the selected participant must provide an explanation.

The EHS Rural Healthcare Network has faced delays in implementing the project schedule due to difficulties that have been encountered in raising necessary eligible matching funds and raising necessary equipment funding that is needed by end user hospitals to make effective use of the network. Now with substantial equipment funding in place, equipment acquired and network matching funds coming into place, a programmatic schedule has been developed for the project. The project schedule identifies the project dates for key milestones. Critical milestones have been met.

Schedule for connecting each site to the network and operational Now that a vendor has been selected for network design, a revised and more current schedule is being developed for connecting each site to the network and making the sites operational.

The current priority for connectivity is the Rhea Medical Center in Dayton as this involves new construction and new relationships and will allow us to initially pilot all of the issues that will be faced throughout the system deployment.

Schedule Changes:

Erlanger Health System has met the requirements set by the FCC for having completed the process necessary to secure at least one Funding Commitment Letter (FCL) prior to June 30, 2011.

The project was initially delayed due to match issues, planning needs and regional economic fallout from a national recession/depression. Erlanger Health System had needed more time during the project to raise additional needed matching funds

along with raising other funds for non-FCC eligible expenses while also planning how healthcare services will be delivered over the fiber network. EHS has also invested considerable time in developing a basic strategy for delivery of key medical services over the network which is viewed as critical to the sustainability of the network over time. The strategy for delivery of sustainable services over the network has also demonstrated the importance of scaling the number of "partner" hospitals on the network. This need for more partner primary health care providers in turn lead to additional local investment by Erlanger and additional grant proposal development for funding equipment at these potential sites. This has taken considerably more time than originally estimated, while also impacting the facility planning process. Complicating this matter further has been a national economic crisis which has threatened the very survival of at least three of our partner hospitals and required time of project staff to develop funding strategies aimed at saving two of the most isolated rural health care facilities (Copper Basin Medical Center, North Valley Medical Center) and a major hospital partner located in North Georgia (Hutcheson Medical Center).

Some sites selected for the USDA funded telemedicine equipment are initially being served by existing lower capacity internet connections such as T-1's which will not allow for high speed transmitting of large data files, or good quality digital imagery, or significant multiple applications, but still provide a good beta evaluation for the ultimate system because not only will equipment be thoroughly vetted, processes and procedures will be tested and changed as needed.

9. **Provide detail on whether network is or will become self sustaining. Selected participants should provide an explanation of how network is self sustaining.**

A sustainability plan has been developed for the project and is attached. The network will prepay leased fiber where available and construct new fiber in gaps where needed. Project staff have been meeting with electric power distributors (including the Tennessee Valley Authority which has numerous major electric transmission corridors) across the region to map available fiber and plan routing where existing dark fiber is available. In many rural areas these are existing non commercial fiber networks developed for electric distribution system management by rural non-profit electric distributors. In some locations it will be necessary to construct some new fiber along portions of the proposed healthcare route where gaps in existing service are present. The construction of new fiber will create the opportunity for the rural healthcare network to potentially lease excess capacity to generate revenue to help sustain the rural healthcare network. The ability to lease excess capacity is highly dependent on broadband demand which may or may not be present in those rural markets. Therefore the network will look to traditional sources of sustainability such as revenue from the existing Rural Health Care Program, grants, state appropriations, in-kind support, membership or connectivity fees, and perhaps a major donors program.

While those traditional sources are critical to sustainability, they are only effective if the network is properly marketed and targeted to meet needs of the participants, provide services and also clearly provide or enhance the opportunity for downstream health care revenue. To be successfully sustained, a regional telemedicine network must meet the clinical, educational and economic needs of all participants. Erlanger Health System views the project as an opportunity to not only partner with member hospitals, but perhaps more importantly reach out to physicians and distant communities as well. Erlanger has utilized a collaborative needs assessment to ensure that what is offered and communicated to members is what is needed to extend care access and offer programs not yet available because of sparse or dispersed populations. Erlanger continues exploring opportunities to partner with target community health and wellness agencies to pursue both State and Federal funds for initiatives that target maternal/fetal health, children's health, and improvement of critical disease states such as diabetes, stroke, obesity, cancer and COPD. Working with the agencies, Erlanger is also developing community-based health initiatives supported by the increased access to specialists and educational opportunities provided by telemedicine.

Sustainability and long term growth will be enhanced by the creation of an ongoing flow of data between network sites which will quickly demonstrate the benefit to physicians, patients and providers. The initial program focus is centered on both stroke and trauma care which are specialty services in which Erlanger is a broadly recognized leader. These are also services that are significant positive revenue generators for Erlanger and which because of their downstream revenue can justify some subsidization of the telemedicine network by EHS if that is necessary.

Erlanger's business model for the initial phase of telemedicine services focuses on development of a regional telestroke network to expand the existing stroke program at Erlanger. The Erlanger Southeast Regional Stroke Center is a recognized national leader in three core areas: clinical care, stroke education and medical research. The telestroke strategy will focus on the FCC project targeted hospitals and will initially use the USDA funded equipment for patient interface. Erlanger recognizes that telemedicine programs are largely mission driven and rely on down stream revenue generated by capture of new market share as well as grants to assist with start up capital expenses. Erlanger launched an extensive public information awareness program to build regional public awareness of the stroke therapies which will be the lead initial service of the telemedicine initiative.

The strongest and most effective telemedicine systems typically begin operating in support of key services essential to the health of distant communities. The stroke service is an important business unit for Erlanger Health System due to its high profile in the media as well as its excellent reimbursement, profit, and contribution margin. Erlanger projects a modest but sustainable return in net income which will help sustain costs of the developing telemedicine network and grow with services over time.

The network plans to pre pay fiber leases which will reduce start up costs. EHS intends to earn initial revenue downstream in the patient care cycle by growing market share and through linking rural emergency care to Erlanger's Level 1 Trauma Center capabilities. In addition network staff will seek network revenue through traditional telemedicine funding sources as well as by marketing initial excess network capacity to help underwrite operational and maintenance costs.

Additional Quarterly Report Questions for Item 9:

1. Which scenario's fit your project?

Erlanger solicited Request for Proposals which predominantly followed Scenario # 9 (Prepaid lease) with some remote linkages that must be built, being Scenario #2 (Participant owns 100% of dedicated network; Excess bandwidth is owned for current or future use).

EPB is the predominant fiber network in our service area, through their investments much more rural fiber has become available to pre-lease. Dark or unused fiber is available in significant portions of our rural area through other rural electric power distributors which use the fiber to operate their systems. The rural healthcare network is negotiating a proposal from EPB for 15 year pre-leasing of segments of their fiber and anticipates pre-leasing additional segments of dark fiber through EPB from other electric cooperatives. However it is still anticipated that some network links will need to be constructed to access some remote hospitals such as Copper Basin Medical Center and the Rhea Medical Center with desired fiber.

Nationally demand for telehealth services is growing in such areas as ICU monitoring, mobile applications via handheld devices (countless IPAD medical applications now exist), expansion into long term care facilities, home and remote patient monitoring etc. Since we expect the network to continue to grow over time in both connections and content the network solicited proposals to prelease fiber capacity based on scalable demand up to 100 Mb and where fiber needs to be constructed, the network solicited proposals on both 24 and 48 strands of fiber to rural participating hospital locations on a unit cost per mile..

This number of strands will be more fiber than initially needed, but the system is expected to grow substantially over time as new health care provider locations are served and new health care services (including an anticipated move to HD equipment) are developed which will grow bandwidth demand and network traffic. As a result, the network is anticipating leasing some of the excess fiber on an interim basis to generate revenue and services to exclusively fund the operation and maintenance cost of the rural healthcare fiber network during the early years of operation. Discussions with local non-profit utility systems indicate this is feasible. This is important to helping sustain the network in the early years of operation after the pilot program while network applications and network traffic builds to an expected self sustaining volume. Project staff have reviewed other pilot models to

determine appropriate ways to charge for products and services that are a function of the network.

2. Source of 15% funding.
Erlanger Health System is bringing a non-profit group together to provide long term management and maintenance of the actual fiber network. BrightBridge a non-profit regional economic development organization in this partnership is providing the 15 percent matching funds. BrightBridge is a federally certified development corporation that has been involved in the development of EHS's telemedicine initiative since the beginning. Bringing together regional partners for the matching funds is essential in these difficult economic times.

3. Commitments from Network Members.
The BrightBridge Inc. Board of Directors has taken board action approving the commitment of necessary matching funds for the FCC grant.

Prior to posting the RFP, Letters of Agency were secured and submitted to USAC from all participating Health Care Providers. There is no plan at this time to put a mandatory time frame on length of participation in the network as the network is planned to be market driven by demand for services with no cost of entry to eligible participants, only cost for on site connectivity and pro-rata share of network operation and maintenance that is not covered by other income and the revenue generated from potential interim leasing of excess fiber. All of our participating hospitals must have internet accessibility to run their business and stay in business. The problem is they don't have reliable service, it is not fiber, so it is slow and as a result they are limited on size of data that can be transmitted. As long as our network can exceed these very low standards at a comparable price, the market driven strategy will succeed and maintain the commitment from network members.

4. Sustainability Period: Will you be able to supply plan/budget of at least 10 years.

A proposal from EPB has been selected for negotiation which includes pre-payment of fiber leases for 15 years. This amount must be negotiated with projected construction costs to meet the current network budget. However, based on the initial proposal response, it appears the network can be sustainable, the only question is if the total proposed network can be developed or if fiber connectivity can be established in some locations as an alternative to a build out. That is not yet determined.

Erlanger Health System is planning the rural health care fiber network and telemedicine system to be an integral and permanent part of the on-going health care system and not as a temporary pilot project. We anticipate being able to operate the network sustainably for at least a 15 year period, but once the network is operational it will be necessary to review the cost and benefits periodically to assess if it is performing reasonably.

5. Budget attached to Sustainability: One of the key outputs of the Network Design contract will be the development of a detailed capital budget and an operating budget addendum for the Sustainability Plan which will include development of network financial projections and a network operation and maintenance budget.

6.Use of the Network by non-eligible entities.
We currently do not have any non-eligible entities that will be served by the network. The rural healthcare network is currently planning to link rural eligible non-profit health care providers in the FCC funded rural healthcare fiber network and will assess the needs/opportunities of additional eligible for-profit dedicated emergency centers.

To expand or scale the telemedicine network and reach other rural hospitals in Erlanger's multi-state health catchment area, Erlanger Health System and partners will continue applying for additional funding from various sources (USDA, ARC, foundations, etc.) for the acquisition of basic telemedicine equipment to be placed in approximately a dozen additional hospitals beyond the original scope of the project. These additional hospitals will be linked to the FCC funded rural healthcare network at various points by other existing broadband providers.

Several of these future proposed rural health care partner hospitals are private for profit and will require the development of a fair share fee schedule to access the network. The general strategy will be to assess a modest fair share one time initial access fee for joining the network for non-eligible (for –profit health care provider) entities. This one-time fee would be scaled based upon anticipated bandwidth needs. These entities will also incur their own additional expenses for linkage to the rural healthcare network and will share equally in network system operation and maintenance costs with other participants.

A partnership of Erlanger and other non-profits or public entities will pre lease fiber lines for the network and will own all the fiber constructed with the FCC funds. Erlanger expects the usage of the network to grow substantially over time as new telemedicine health care initiatives and applications are developed, deployed and marketed over the secure network. As a result in limited instances where construction of new fiber is required, excess bandwidth is planned in initial construction for future use by network members (Scenario # 2). It is anticipated that portions of this initial excess capacity will be leased where possible in the early years for non-health related purposes with all revenues being used to sustain the network. As health care network demand grows over time, excess bandwidth leased at arms length to other parties will be reduced to meet needs for health care traffic.

7. Management of the Network

Erlanger Health System plans to focus on managing the network content (health care services) and plans through its non-profit partnership to contract with a

qualified public non-profit utility(s) to manage and maintain the physical system network. Erlanger will also maintain ownership of telemedicine stations installed at rural hospital locations and will be able to maintain this equipment more cost effectively through vendor service contract(s).

8. Continued RHC Funding:

   The healthcare network is anticipating that all eligible rural hospitals will seek appropriate internet access funding assistance in the regular Rural Health Care program. Network staff will prepare necessary annual applications relative to the Pilot Program network for eligible member hospitals.

9. State and Federal Funding:

   As noted throughout the report, Erlanger Health System or various network supporters have been actively pursuing state and federal funding to add equipment and fiber to the network. This will continue until the network is fully developed with service to all hospitals, public primary care centers, and public health departments throughout the multi-state service area of Erlanger Health System. Erlanger Health System has already secured additional federal funding needed to equip rural hospitals in the initial FCC funded project with interactive telemedicine stations. Initial telemedicine station equipment purchase costs have been a little lower than projected costs, so EHS hopes to be able to equip a few more of the hospitals in the FCC project through these savings. Additional grant funds will continue to be requested from appropriate sources to add additional telemedicine equipment to more hospitals.

10. Prepaid Lease Option:

    Due to rapid advances in the availability of broadband fiber in rural portions of the rural healthcare service area, proposals for pre-paid leasing were requested and received.

10. **Provide detail on how the supported network has advanced telemedicine benefits.**

    Erlanger Health System has continued work on planning the physical and programmatic structure of the network by hiring staff and committing hundreds of thousands of local dollars to the effort. Funding of this pilot project and the on-going project planning has catapulted telemedicine to a realistic opportunity in our regional medical community. The FCC grant has generated extensive discussion in the regional medical community on how best to use telemedicine to improve the quality of health care and drive down costs. Also as a direct result of this project one private medical group moved to raise foundation funding for delivery of demonstration telemedicine consultations through leased lines to remote rural residents for specialty needs in perinatology. This particular example has provided new access in remote

rural communities to specialized services needed to effectively deal with problem pregnancies which result in higher infant mortalities in the network service area. Plans have also been developed for providing stroke consultation services from Erlanger's stroke center to primary health care locations across the region and linking the level 1 trauma center specialists at Erlanger's Baroness Hospital in Chattanooga to the rural hospital emergency rooms for real time consultation and determination of treatment options.

Public Health Departments across the service area have also expressed an interest in linking with the rural healthcare network and have been collaborating in seeking additional funding to expand the planned network.

Blue Cross Blue Shield of Tennessee the dominant health insurance company in Tennessee has also been studying how to encourage preventive care using tools such as telemedicine and they have taken steps that will result in paying for certain telemedicine services.

11. **Provide detail on how the supported network has complied with HHS and IT initiatives:**

Since the network has not been leased/constructed and is not operational at this time, this is not applicable. However staff involved with the Pilot Project have participated in training sessions presented by HHS staff through USAC sponsored training and are continuing to learn more about these initiatives and the opportunities they present.

12. Explain how the selected participants coordinated in the use of their health care networks with the Department of Health and Human Services (HHS) and, in particular, with its Centers for Disease Control and Prevention (CDC) in instances of national, regional, or local public health emergencies (e.g. pandemics, bioterrorism). In such instances, where feasible, explain how selected participants provided access to their supported networks to HHS, including CDC, and other public health officials.

Since the network has not been constructed and is not operational at this time, this is not presently applicable. However, as previously mentioned in Section 7, the ability to interface the Rural Healthcare Fiber Network through the Erlanger main campus hub with the EPB fiber network system which will reach every doctor's office and every doctor's home (along with every other address) in their six county service area will provide unparalleled regional opportunities for 24/7 remote rural telemedicine access in instances of national, regional or local public health emergencies such as pandemics, natural disasters, or bioterrorism. Given the increasing local experience with widespread floods, tornadoes, snowstorms, rock slides across key highways, train derailments, etc. this capacity may be critical to just simply integrating telemedicine into the ordinary delivery of health care in our region.